DEPARTMENT	OF HEALTH AND HUMAN SERVICES	
CENTERS FOR	MEDICARE & MEDICAID SERVICES	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		ONSTRUCTION 01	(X3) DATE S COMPL	ETED	
		155233	B. WIN	G		09/09/2011	
	PROVIDER OR SUPPLIER			958 E F	ADDRESS, CITY, STATE, ZIP CODE HWY 46 VILLE, IN47006		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0000	State Licensure State Indiana State accordance with Survey Date: 09. Facility Number: Provider Number AIM Number: 1 Surveyor: Mark Specialist  At this Life Safet Waters of Batesv compliance with Participation in NCFR Subpart 483 Fire and the 2000 Fire Protection A Life Safety Code Existing Health C410 IAC 16.2.  This one story fabe of Type V (11 sprinklered. The system with smood corridors, spaces and single station	000138 r: 155233	K	0000	Preparation and/or execution this Plan of Correction in ger or this corrective action in particular, does not constitute admission or agreement by the facility of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction and specificorrective actions are preparand/or executed in compliant with state and federal laws.	neral, e an his he fic ed	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

STX321

Facility ID:

000138

If continuation sheet

ll í			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPL	
		155233	B. WIN			09/09/2	011
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
WATERS	OF DATESVILLE	TUE		958 E H	IWY 46 ∕ILLE, IN47006		
	OF BATESVILLE,			L	VILLE, 11147000		
(X4) ID		TATEMENT OF DEFICIENCIES	ID  PROVIDER'S PLAN OF CORRECTION  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)			(X5)	
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)			Έ	COMPLETION DATE	
IAU		· · · · · · · · · · · · · · · · · · ·		IAG			DATE
		and had a census of 83 at					
	the time of this v	ISIT.					
		Robert Booher, Life Safety dical Surveyor on 09/14/11.					
	Cour Specialist 1710.						
	•	nd not in compliance with the					
	•	ulatory requirements as					
	evidenced by the fol	nowing:					
K0048	There is a written	plan for the protection of all	1				
SS=F		eir evacuation in the event					
	of an emergency.		l				
		review and interview, the	K(	0048	It is the intent of this facility to insure a written plan is in plan		10/07/2011
	•	include the use of kitchen			for the use of kitchen fire		
	•	s in the written plan for			extinguisher for the protection	n of	
	•	83 of 83 residents in the			all residents. A. Corrective A		
		gency. LSC 19.2.2.2			Taken: 1. The Fire and Disas		
	requires a writter	n health care occupancy			Manual was updated to inclu the use of the kitchen fire	ae	
	fire safety plan th	nat shall provide for the			extinguisher (K Class) to add	lress	
	following:				the use of Type K class fire		
	(1) Use of alarms	5			extinguisher in relationship w		
	(2) Transmission	of alarm to the fire			the use of the kitchen overhe extinguisher system and a	ad	
	department				placard posted next to the		
	(3) Response to a	alarms			extinguisher indicating its use	e is	
	(4) Isolation of fi	re			secondary to the hood		
	(5) Evacuation of	f immediate area			extinguishing system. 2. All have been inserviced on the	staff	
	(6) Evacuation of	f smoke compartment			updates to the Fire and Disas	ster	
	(7) Preparation o	f floors and building for			Manual. B. Others Identified		
	evacuation				There were no other resident	is	
	(8) Extinguishme	ent of fire			having the potential to be	3. 1	
	This deficient pra	actice affects all residents			affected. C. Measures Taker All staff were inserviced on n		
	in the facility.				updates to the Fire and Disas	-	
					Manual 2. The Maintenance		
	Findings include	:			Supervisor/designee will mor		
			<u> </u>		and insure posting of the place	cards	

000138

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	01	COMPL	
		155233	B. WING			09/09/2	011
NAME OF E	PROVIDER OR SUPPLIER		<del>' T</del>	STREET AI	DDRESS, CITY, STATE, ZIP CODE		
				958 E H\			
WATERS	OF BATESVILLE,	THE		BATESV	'ILLE, IN47006		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	Τ.	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG			DATE
TAG	Based on a review fire disaster plan The Waters of Ba 8:45 a.m. with m fire disaster plan of the ABC type K class fire extinkitchen in relation kitchen overheads. Furthermore, the extinguisher and extinguisher lacks their use is second hood extinguishing interview with m the administrator a.m., the kitchen activate the overlaystem to suppreseither the ABC to the K class fire extinguisher and in the Kindred Extendire the ABC to the K class fire extinguisher and in the Kindred Extendire the ABC to the K class fire extinguisher and in the Kindred Extendire the ABC to the K class fire extinguisher and in the Kindred Extendire the ABC to the Kindred Extendire the ABC to the Kindred Extendire the ABC to the Kindred Extendire the Kindred Extendire the Kindred Extendire the ABC to the Kindred Extendire the Kindred Extendire the ABC to the Kindred Extendire the Kindred Extendire the ABC to the Kindred Extendire the Kindred Extendire the ABC to the Kindred Extendire the Kindred Extendire the Kindred Extendire the Kindred Extendire the ABC to the Kindred Extendire the Kind	w of the facility's written labeled Disaster Plan for atesville on 09/09/11 at maintenance aide # 1, the did not address the use fire extinguisher and the aguisher located in the maship with the use of the dextinguishing system.		TAG	in the kitchen area. D. How Monitored: 1. The Maintenar Supervisor/designee will con an monthly audit to insure placards are in place as a pathe Preventive Maintenance Program. 2. All new staff will receive a copy of the update. Fire and Disaster Manual. 3. CEO/designee will review the results of the monthly audits the quarterly QA & A Commit meetings. E. This plan of correction constitutes our creallegation of compliance with regulatory requirements, our of completion is 10/7/2011.	nce duct  If of The e at ttee	DATE
FORM CMS 2	567(02-99) Prayious Varsio	ons Obsolete Event ID: C	TV324	Facility II	D. 000138 If continuation of	neet Do	go 3 of 11
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID: S	TX321	Facility II	D: 000138 If continuation sl	neet Pa	ge 3 of 11

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI			JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIC	01	COMPL	ETED
		155233	A. BUII			<del></del>	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER						
\A/ATEDO	OF DATEOWILE			958 E F			
WATERS	OF BATESVILLE,	IHE		BAIES	VILLE, IN47006		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0052	-	n required for life safety is					
SS=F	installed, tested, a						
		IFPA 70 National Electrical  2. The system has an					
		ance and testing program					
	* *	plicable requirements of					
	NFPA 70 and 72.	· · · · · · · · · · · · · · · · · · ·					
		d interview, the facility failed to	KO	052	It is the intent of this facility to	o	10/07/2011
		m boxes were located not less		-	insure all fire alarm boxes ar		
	•	nore than 4 1/2 feet above the to NFPA 72, the National Fire			located properly to meet set		
		2-8.1 requires the operable part			standards.		
	of each manual fire alarn	n box shall be not less than 3					
	•	an 4 1/2 feet above the floor.			A. Corrective Action Ta		
	This deficient practice co facility.	uld affect all residents in the			1. All 16 fire alarm bot	kes	
	racincy.				were repaired to meet set standards		
	Findings include:				B. Others Identified:		
					1. Maintenance		
	Based on observatio	n and measurement of fire			Supervisor/designee comple	ted a	
		9/11 during a tour of the			100% audit of all facility fire a		
		m. to 12:30 p.m. with			boxes to insure they meet se		
		1, the following fire alarm			standards.		
		between four feet nine inches			C. Measures Taken:		
		ches above the floor: the one			1. Maintenance		
		F Hall, the one fire alarm box			Supervisor/designee will moi		
		the one fire alarm box at the			all of the fire alarm boxes mo	nthly	
		tion, the one fire alarm box in the			as a part of the Preventive		
	· · · · · · · · · · · · · · · · · · ·	ning room, the one fire alarm			Maintenance Program for compliance.		
		by the dining room smoke			D. How Monitored:		
		e fire alarm box in the corridor			1. The CEO/designee	will	
	•	ctor of nursing office, the two			review the results of the mor		
		he ICF Hall by the smoke			audits at the quarterly QA &	-	
		e fire alarm box in the			Committee meetings.		
		Hall by the smoke barrier			E. This plan of correcti		
		larm box in the Rehabilitation			constitutes our credible alleg		
		oke barrier doors, the one fire			of compliance with all regula	tory	
	-	nt nurses' station, the one fire			requirements, our date of		
	alarm box in the Ada	ministration Hall by the exit			completion is 10/7/2011.		
		fied by maintenance aide # 1 at					
	the time of observat	ions and confirmed by the					
		-	1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155233 09/09/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 958 E HWY 46 WATERS OF BATESVILLE, THE BATESVILLE, IN47006 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE administrator at the 12:30 p.m. exit conference on 09/09/11. 3.1-19(b)Cooking facilities are protected in accordance K0069 19.3.2.6, NFPA 96 with 9.2.3. SS=E Based on observation and interview, the facility failed It is the intent of this facility to K0069 10/07/2011 to maintain 2 of 2 portable fire extinguishers in the maintain the kitchen fire kitchen cooking area in accordance with the extinguisher in the kitchen requirements of NFPA 96, 7-2.1.1 which requires a cooking area to meet set placard identifying the use of the extinguisher as a standards. secondary backup means to the automatic fire suppression system shall be conspicuously placed near each portable fire extinguisher in the cooking A. Corrective Action Taken: area. Additionally, NFPA 10, 1998 Edition, 2-3.2 A placard was posted requires fire extinguishers provided for the protection next to the Type K portable fire of cooking appliances use combustible cooking media extinguisher located in the kitchen (vegetable or animal oils and fats) shall be listed and cooking area. labeled for Class K fires. NFPA 10, 2-3.2.1 requires a B. Others Identified: placard shall be conspicuously placed near the extinguisher which states the fire protection system 1. No others areas were shall be activated prior to using the fire extinguisher. identified as affected. Since the fixed fire extinguishing system will Measures Taken: C automatically shut off the fuel source to the cooking Maintenance 1 appliance, it is preferential to activate the fixed system Supervisor/designee will monitor before using a portable fire extinguisher. In this the placement of the placard instance, the portable fire extinguisher is monthly as a part of the supplemental protection. This deficient practice could affect any residents using the main dining room, Preventive Maintenance Program located adjacent to the kitchen. to assure set standards are being met. Findings include: D. How Monitored: The CEO/designee will 1. Based on observation on 09/09/11 at 10:40 a.m. with review the results of the monthly maintenance aide # 1, there were two portable fire extinguishers in the kitchen. One, an ABC type, was audits at the quarterly QA & A conspicuously placed on the west wall of the kitchen Committee meetings. near the food storage room and the second This plan of correction extinguisher, a K class, was located on the east wall constitutes our credible allegation and both fire extinguishers lacked placards. Based on of compliance with all regulatory interview on 09/09/11 at 10:55 a.m. with maintenance requirements, our date of aide # 1, it was acknowledged the ABC type and K class type portable fire extinguishers in the kitchen completion is 10/7/2011. lacked placards identifying their use as secondary backup to the automatic fire suppression system located near the stove hood. This was verified by the

000138

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	II DING 01		COMPLETED	
		155233	B. WING	J	<del></del>	09/09/2	011
			_	REET AD	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			8 E HV			
WATERS	OF BATESVILLE,	THE			ILLE, IN47006		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAC	G	DEFICIENCY)		DATE
	administrator at the 0 conference.	9/09/11, 12:30 p.m. exit					
K0143 SS=E	(a) separated from wherein patients a treated by a separal-hour fire-resistiv (b) in an area that sprinklered, and had flooring; and (c) in an area post transferring is occur the immediate are accordance with N Compressed Gas Based on observation to ensure 1 of 1 oxyg transfer occurs was pare fire rated door. This cresidents on ICF Hall Findings include:  Based on observation maintenance aide # 1 on the corridor door to ICF Hall near the nurit was at least a 45 m interview on 09/09/11 aide # 1, it was acknown in the oxygen storage corridor door fire ration on door was illegible.	n any portion of a facility are housed, examined, or ration of a fire barrier of e construction; is mechanically ventilated, as ceramic or concrete  and with signs indicating that turring, and that smoking in a is not permitted in IFPA 99 and the	K0143		It is the intent of this facility to insure the Oxygen Storage R has a 45 minute fire-rated do  A. Action Taken:  1. The facility has repl the Oxygen Storage Room dand has documentation show fire ratings to meet set stands.  B. Others Identified:  1. There is no other Oxygen Storage Room.  C. Measures Taken:  1. Maintenance  Supervisor/designee will commonthly audits to insure prop documentation is in place as part of the monthly Preventiv Maintenance program  D. How Monitored:	aced oor ving ards. duct eer a	10/07/2011

AND PLAN OF CORI	RRECTION	IDENTIFICATION NUMBER:	A BIIII	DING	01	COMPL	ETED
		455000	A. BUILDIN			COMPLETED	
		155233	B. WINC		<del></del>	09/09/20	011
			D. WINC		DDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDE	ER OR SUPPLIER			958 E H			
WATERS OF BA	BATESVILLE,	ГНЕ			/ILLE, IN47006		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	DROWINED'S DLAN OF CORRECTION		(X5)
PREFIX (I	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPRO		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	_	COMPLETION
TAG RE	EGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
SS=F exerce mont 3.4.4 Base faciling generation from the station of the station o	cised under loth in accordant 4.1.  ed on observative failed to derators was perional alarm lily observed gular work states. NFPA 99 1.1.15 require age battery per perate outside location read rating personation. The annum conditions iliary powers andividual visity when the emerger source is coad.  When the batter functioning. Individual visits andividual visits functioning.	appected weekly and ad for 30 minutes per ce with NFPA 99.  Intion and interview, the ensure 1 of 1 emergency provided with a cannunciator in a location by operating personnel at ation such as a nurses' 10. Health Care Facilities, es a remote annunciator, owered, shall be provided to of the generating room ally observed by the lat a regular work anciator shall indicate of the emergency or ource as follows: the unitary operating to supply power the ery charger is the signals plus a signal to warn of an	K0	144	1. The CEO/designee review the results of the mon audits at the quarterly QA & A Committee meetings.  E. This plan of correctic constitutes our credible allegate of compliance with all regulate requirements, our date of completion is 10/7/2011.  It is the intent of this facility to insure that the emergency generator is provided with a functional alarm annunciator location readily observed by operating personnel.  A. Action Taken:  1. The remote general alarm annunciator was relocated a readily-observed nurses station.  B. Others Identified:  1. The facility only has generator.  C. Measures Taken:  1. The Maintenance Supervisor/designee will mor proper operation of the removalerm monthly as a part of the Preventive Maintenance Program.  D. How Monitored:  1. The CEO/designee review the results of the moraudits at the quarterly QA & A Committee meetings.  E. This plan of correctic constitutes our credible allegated.	thly A on ation cory  in a tor ated s one mitor te e will nthly A on	10/07/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155233		LDING	01	09/09/2	
		100200	B. WIN		A DDDEGG CITY GTATE ZID CODE	03/03/2	011
NAME OF I	PROVIDER OR SUPPLIE	₹		958 E F	ADDRESS, CITY, STATE, ZIP CODE		
WATERS	OF BATESVILLE,	THE		1	VILLE, IN47006		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	engine-generator alarm condition shall				of compliance with all regula requirements, our date of	tory	
	indicate:				completion is 10/7/2011.		
	1. Low lubrication						
	2. Low water ter	-					
	3. Excessive wat	•					
		en the main fuel storage					
		s than a 3-hour operating					
	supply.						
	5. Overcrank (fa	iled to start).					
	6. Overspeed.						
	Where a regular work station will be						
	unattended periodically, an audible and						
	1	ent signal, appropriately					
	labeled, shall be						
	1	onitored location. This					
		nal shall activate when					
	1 -	tions in 3-4.1.1.15(a) and					
	` ′	ed not display these					
		idually. This deficient					
	1 ^	fect all the residents as					
	well as visitors a	and staff.					
	D. 1 1 1						
	Findings include	<del>.</del> .					
	Based on observ	ation on 09/09/11 at					
	11:15 a.m. with	maintenance aide # 1, the					
	remote alarm an	nunciator for the					
	generator was pr	ovided in the transfer					
	1 -	cated down the corridor					
	1	Il nurses' station.					
		e test switch on the remote					
	1	or was tested and the					
		ould not be heard at the					
		station with the transfer					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
AND PLAN	OF CORRECTION	155233	A. BUII	LDING	01	09/09/201 <sup>2</sup>	
		100200	B. WIN		DDDEGG GITTL GTATE ZID GODE	03/03/201	'
NAME OF P	ROVIDER OR SUPPLIER			958 E H	ADDRESS, CITY, STATE, ZIP CODE		
WATERS	OF BATESVILLE,	THE			VILLE, IN47006		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		E C	OMPLETION DATE
IAG				TAG	DLI ICILI (C.1.)		DATE
		r closed. Based on an aintenance aide # 1 on					
		a.m., the remote alarm he emergency generator					
		d with the door closed					
		adily observed by staff					
	during all shifts.	dully observed by stall					
	during an sinits.						
	3.1-19(b)						
	3.1 19(0)						
K0154		automatic sprinkler system					
SS=F	is out of service to 24-hour period, the	r more than 4 hours in a					
		ed, and the building is					
	evacuated or an a	pproved fire watch system					
		parties left unprotected by					
	been returned to s	the sprinkler system has					
		review and interview, the	K	)154	It is the intent of this facility to	o   1	10/07/2011
		fire watch policy failed to	1	,,,,,	insure identification of the pe		10/0//2011
	_	on or persons assigned to			or persons who will conduct	the	
		facility during the fire			fire watch and whose sole responsibility it is to complete	a the	
		nt the automatic sprinkler			fire watch.	, 110	
		placed out of service for					
	•	in a 24 hour period to			A. Action Taken:	tor	
		residents in accordance			<ol> <li>The Fire and Disas         Manual has been updated to     </li> </ol>	I .	
	•	on 9.7.6.1. LSC 9.7.6.2			insure the Emergency		
		r impairment procedures			Assignments are listed and the		
		PA 25, Standard for			responsibilities to that role or 2. All staff were inserv	· 1	
	Inspection, Testin	ng and Maintenance of			on updates to the Fire and		
	Water-Based Fire	e Protection Systems.			Disaster Manual.		
	NFPA 25, 11-5(c)	)2 requires an approved			B. Others Identified:		
	fire watch to be i	mplemented in the event			<ol> <li>The facility only has Fire and Disaster Manual.</li> </ol>	one	
	the automatic spr	rinkler system has to be			C. Measures Taken:		
					1. Maintenance		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

STX321

Facility ID: 000138

If continuation sheet

Page 9 of 11

		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155233	A. BUILI		<u>01</u>	09/09/2	
		100200	B. WING		DDDECG CITY CTATE 7ID CODE	03/03/2	011
NAME OF F	PROVIDER OR SUPPLIER			958 E H	DDRESS, CITY, STATE, ZIP CODE		
WATERS	OF BATESVILLE,	ГНЕ			/ILLE, IN47006		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	Supervisor/designee will revi	0147	DATE
	*	vice for 4 hours or more			Emergency Assignments mo		
	•	od. LSC 3.3.77 defines a			at fire drills and yearly fire an		
	•	erson or persons assigned			disaster inservices.		
		purpose of protecting the			D. How Monitored:		
	occupants from f				<ol> <li>CEO/designee will monitor monthly fire drills and</li> </ol>	,	
		is deficient practice			yearly fire and disaster inserv		
	could affect all re	esidents in the facility.			results at quarterly QA & A meetings.		
	Findings include				E. This plan of correcti constitutes our credible allegations.	ation	
	Based on a review	w of the Fire Watch			of compliance with all regulat	ory	
		11 at 8:45 a.m. with			requirements, our date of completion is 10/7/2011.		
		e # 1, the Fire Watch			completion is 10/1/2011.		
		comatic sprinkler system					
	=	tion of the person or					
		ald perform the fire watch					
	_	utomatic sprinkler					
		f service for four hours					
	•	nty four hour period.					
		by the administrator at					
		conference at 12:30 p.m.					
	the 09/09/11 Calt	conference at 12.30 p.m.					
	3.1-19(b)						
K0155 SS=F	service for more the period, the authorical notified, and the brapproved fire water left unprotected by alarm system has	fire alarm system is out of nan 4 hours in a 24-hour ty having jurisdiction is uilding is evacuated or anoth is provided for all parties the shutdown until the fire been returned to service.					
		review and interview, the policy in the event the	K01	155	It is the intent of this facility to insure a written policy to iden the person or persons assign	tify	10/07/2011

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	(X2) MULTIPLE CO  A. BUILDING  B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 09/09/2011
	PROVIDER OR SUPPLIER  OF BATESVILLE,  SUMMARY S		STREET A 958 E H	VILLE, IN47006	(X5)
PREFIX TAG	· `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
IAU	fire alarm system service for 4 hour period failed to it persons assigned facility during the of 83 residents in Section 9.6.1.8. Watch as a personal area for the procupants from from the emergencies. The could affect all results of the procupants included Based on a reviet Policy on 09/09/maintenance aided Policy for the first fire watch would period the fire all service for four hour period. Policy lacked idea or persons who watch in the even was out of service in a twenty four verified by the acceptance of the period of the fire all services for four hour period.	n has to be placed out of rs or more in a 24 hour dentify the person or to each area of the e fire watch to protect 83 n accordance with LSC, LSC 3.3.77 defines a fire n or persons assigned to urpose of protecting the fire or similar his deficient practice esidents in the facility.		to each area of the facility da fire watch.  A. Action Taken 1. The facility Fire an Disaster Manual was update show Emergency Assignment and their sole responsibility the fire watch. B. Others Identified: 1. The facility has on Fire and Disaster Manual. C. Measures Taken: 1. Maintenance Supervisor/designee will reverse and provides and yearly fire and disaster inservices. D. How Monitored: 1. CEO/designee will monitor monthly fire drills are yearly fire and disaster Inservices at quarterly QA & A meetings. E. This plan of correct constitutes our credible alleged from the plant of completion is 10/7/2011.	d ed to ents during  ly one riew onthly nd  rvice tion gation